



# Personal mental health treatment stigma, perceived caregiver and peer treatment stigma, and help-seeking behaviors among adolescents

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## ABSTRACT

Most adolescents with mental health symptoms do not receive formal mental health care, and minoritized adolescents are disproportionately likely to report unmet treatment needs. Social Learning Theory and the Theory of Planned Behavior suggest that interpersonal processes may shape adolescents' perceptions of others' and their own mental health treatment stigma, which has been emphasized as one key barrier to accessing care. This study examines associations from peer and caregiver mental health treatment stigma to adolescents' personal mental health treatment stigma and formal psychological support-seeking. Self-report survey data were collected from a community sample of 3248 6th through 12th graders enrolled in six public schools in Fall 2020. In this sample, 36.4% of White youth reported seeking formal psychological support, the highest rate in the sample. Asian American youth reported the highest level of personal treatment stigma ( $F = 4.02, p < 0.01$ ), and Asian American and Latin(x) youth reported highest levels of caregiver-held stigma ( $F = 14.09, p < .001$ ). Trans, nonbinary, and gender expansive youth reported the highest rates of personal, peer, and caregiver stigma ( $F_s > 4.95; p_s < 0.01$ ), and the highest rate of seeking formal psychological care (48.3%). Personal treatment stigma partially mediated associations from caregiver and peer treatment stigma to formal psychological help seeking, with diverging associations from peer and caregiver perceived stigma to reported help-seeking. This work emphasizes the need for identity-responsive care and interventions that consider the social and familial context in stigma reduction efforts.

## 1. Introduction

Most adolescents with mental health symptoms do not receive mental health care (Duong et al., 2021; Lu et al., 2021). Barriers to adolescent engagement with the mental health system include *logistical* barriers (e.g., costs, transportation, capacity to consent) and *perceptual* barriers (e.g., personally-held beliefs about mental health care; Roberts, Jones, Garcia, & Techau, 2022). Personal mental health treatment stigma—holding negative attitudes and beliefs about people receiving mental health care—has been emphasized as one key perceptual barrier that affects adolescents (Clement et al., 2015). Adolescents are highly susceptible to social influence (Somerville, 2013), and close others'

beliefs about mental health care may shift their own beliefs. Mental health symptoms and treatment attitudes that develop in adolescence often persist into adulthood and can negatively impact lifelong well-being and access to care (Uhlhaas et al., 2023). The current study examines whether mental health treatment stigma held by adolescents, their peers, and their caregivers is associated with adolescents' use of formal psychological support services. Given disparities in both unmet mental health needs and access to care for adolescents holding marginalized identities (Murthy, 2022), we explore differences in stigma and formal psychological support-seeking by racial and gender identity. By integrating caregiver, peer, and personal stigma within a single model, this study aims to advance understanding of the social

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mechanisms through which stigma may perpetuate mental health disparities.

This study is guided by principles of Social Learning Theory, which describes how adolescents acquire beliefs through observing the attitudes of close others (Akers & Jennings, 2015). Peers and parents each serve as powerful sources of information during this developmental stage (De Los Reyes & Epkins, 2023). There has been some debate about how the roles of parents and peers interact and combine to shape attitudes during adolescence (Allen, Costello, Kansky, & Loeb, 2022), but little is known about how adolescents' perceptions of treatment stigma held by each of these sources may influence their own personally held treatment stigma. Treatment stigma, held by self and others, may be vital in shaping adolescents' actual help-seeking behavior. According to the Theory of Planned Behavior, intentions to act are shaped by personally held attitudes (e.g., "seeking help is bad"), subjective norms (e.g., the perception of social disapproval, as represented by the perception of others' stigma), and perceived behavioral control (e.g., confidence that one could access and benefit from care; Godin & Kok, 1996). Therefore, adolescents' tendency to pursue mental health support could be shaped through their personal mental health stigma (which may be shaped by others' stigma, per Social Learning Theory) and through their perceptions that others hold mental health stigma (per Theory of Planned Behavior). We discuss specific mechanisms by which these learning processes may transfer, below.

Caregiver and peer mental health treatment stigma both offer information that may inform adolescents' own beliefs about mental health and treatment-seeking. Caregivers provide implicit messaging (e.g., modeling/the degree of caregivers' own interactions with mental health treatment) and explicit messaging (i.e., direct communication about mental health treatment as a "good" or "bad" thing) that could shape adolescents' personal beliefs about mental health treatment (Negussie, Geller, DeVoe, & National Academies of Sciences, Engineering, and Medicine, 2019). Perceived caregiver stigma may be a particularly potent source of influence over adolescents' engagement with mental health care, given that caregivers are key sources of logistical support necessary to facilitate treatment (Austin et al., 2025). Previous work has highlighted that caregiver stigma is associated with reduced tendency of caregivers to seek mental health care for their children (Burke, Callear, Cruwys, & Batterham, 2023). Caregiver stigma may shape adolescents' use of mental health care through attitudinal and logistical mechanisms.

In addition to caregiver influence, prior work has emphasized the importance of peer influence in adolescence. Youth often choose friends who hold similar beliefs to them (i.e., selection effects) and then reinforce and strengthen these beliefs in one another (i.e., socialization effects; Giletta et al., 2021). Furthermore, adolescents' sensitivity to social evaluation may exacerbate imagined consequences of behaving (or even believing) differently than their peers (Somerville, 2013). Adolescents who perceive their peers to hold strong mental health treatment stigma may internalize this stigma themselves (Chandra & Minkovitz, 2006). Alternatively, even if an adolescent does not hold personal treatment stigma, they may refrain from seeking mental health treatment to avoid social consequences (Nearchou et al., 2018; Villatoro, DuPont-Reyes, Phelan, & Link, 2022). Since the confluence of caregiver and peer messaging in adolescence is a powerful and complex socializing agent (Telzer, Dai, Capella, Sobrino, & Garrett, 2022), the current study characterizes how perceptions of both caregiver and peer mental health treatment stigma are associated with adolescents' personal mental health treatment stigma.

Additionally, cultural and identity factors shape adolescents' experiences of the mental health care system, the messaging they receive about help-seeking, and their mental health and well-being. Adolescents from minoritized backgrounds experience disproportionately unmet mental health needs and disparities in access to mental health care (Murthy, 2022), which can reinforce mental health treatment stigma for adolescents, peers, and families, who hold marginalized identities (Ahad, Sanchez-Gonzalez, & Junquera, 2023). For example, adolescents

who hold minoritized identities are less likely to access and stay in mental health treatment than non-Hispanic, White adolescents (Ringle, Sung, Roulston, & Schleider, 2024), which may be linked to provider discrimination and other systemic barriers (Planey, Planey, Wong, McLafferty, & Ko, 2023; Schmitz & Tabler, 2021). Similarly, caregivers of adolescents from minoritized racial and ethnic backgrounds may hesitate to encourage their children to seek formal psychological support because of historical and ongoing provider bias, a lack of racial representation among providers, and mistreatment by the mental health care system (Lu et al., 2021; Murry, Heflinger, Suiter, & Brody, 2011). In other words, for many families, "stigma" may simply reflect long-standing disparities in the quality of care received. Moreover, cultural differences in stigma held by families and communities can emerge from experiences of historical trauma and systemic oppression, in which the mental health system was either complicit or actively perpetrating (Mullan, 2023). Ultimately, these high rates of self and perceived stigma among minoritized youth and families highlight the ways in which racism and structural inequities perpetuate barriers to mental health treatment (Jon-Ubabuco & Dimmitt Champion, 2019).

Gender identity can also shape societal messaging about mental health and stigma towards engaging mental health care (Brand, Rodriguez-Monguio, & Volberg, 2019). For example, in studies comparing cisgender boys and girls, research generally demonstrates that boys experience more mental health stigma (Pedersen & Paves, 2014; Pfeiffer & In-Albon, 2023). Youth who hold minoritized gender identities have noted barriers to discussing mental health treatment in both heteronormative and queer spaces, including lack of provider understanding or humility discussing identity and mental health, leading to challenges seeking mental health treatment (McDermott, Hughes, & Rawlings, 2018; O'Connor, Pleskach, & Yanos, 2018). A lack of insurance reimbursement and unavailability of gender-affirming providers further impede gender diverse adolescents from accessing formal psychological support (Ebert, Guo, Klein, Doren, & Klement, 2024). Given just these few examples of the role of racial, ethnic, and gender identity stress as associated with mental health treatment, help-seeking must be assessed in the context of health disparities, and should carefully consider differences in perceptions and behaviors for adolescents with minoritized identities. Therefore, the current study also assesses how mental health treatment stigma and formal support seeking in adolescence are associated with one's racial, ethnic, and gender identity.

### Current study

This study examines how peer and caregiver stigma about mental health treatment are each associated with adolescent attitudes and behaviors toward seeking formal psychological help. This study sets forth the following hypotheses:

1. Formal psychological help-seeking, personal mental health treatment stigma, and perceived peer and caregiver mental health treatment stigma will vary by youth race and gender.
2. In a mediation model, after controlling for youth racial identity, gender identity and psychological distress, greater peer and caregiver treatment stigma will be associated with higher levels of personal treatment stigma, which, in turn, will predict lower likelihood of formal psychological help-seeking.

## 2. Methods

### 2.1. Procedures

Data were collected as part of the Substance Use and Risk Factors (SURF) survey in the fall of 2020 from 6th to 12th grade students enrolled in six public schools spanning three districts following procedures laid out in (Costello et al., 2025). Procedures were approved by the Massachusetts General Brigham (MGB) Institutional Review Board.

Student participation occurred through an opt-out consent procedure (distributed in students' preferred language based on reported school need), in which caregivers were given the option to withdraw their child from the optional school-wide survey. If caregivers did not contact study staff prior to the survey date, passive consent for survey participation was assumed. The Survey was voluntary, with student assent implied by completing the survey. Participating schools and districts were aware in agreement with the opt-out and passive consent process. Students were eligible to participate if their parent did not submit an opt-out form, if they attended a participating school on the date that the survey was administered, and if they were able to read and write in one of the available survey languages (specified below).

## 2.2. Survey administration

Surveys were completed electronically during school periods (e.g., homerooms, advisory periods). Proctoring teachers introduced the survey using an IRB-approved script describing the purpose of the study and informing students that participation was voluntary. Students were provided a description of the survey in writing which communicated the purpose of the survey, that survey is voluntary, that their responses would be kept confidential, and to communicate to the study team with any questions. Students entered responses directly into REDCap, a HIPAA compliant platform for electronic data capture hosted on internal hospital servers. SURF Survey and accompanying opt-out consent documents were available in Amharic, Arabic, Bengali, Brazilian Portuguese, Chinese-Mandarin (Simplified), Dari, English, Farsi, Filipino, French, Gujarati, Haitian-Creole, Russian, Spanish, Turkish, Ukrainian, and Vietnamese. Data were kept confidential and stored in a secure, coded dataset.

## 2.3. Measures

### 2.3.1. Demographic characteristics

**Grade.** Participants indicated their grade using a checkbox format with options from 6th to 12th grade.

**Gender.** Participants were asked "What best describes your gender?" and were given options of: "Female," "Male," "Transgender Female (male to female)," "Transgender Male (female to male)," and "Nonbinary." While all five categories were presented descriptively, categories were re-coded into cisgender female, cisgender male, and transgender and nonbinary youth for primary analyses.

**Race and Ethnicity.** Participants were asked, "What is your race (check one)?" and given the following options: "White," "Haitian, Black or African American," "Asian," "Hawaiian or Other Pacific Islander," "American Indian/Alaska Native," "More than One Race," or "Other." Hispanic/Latinx identity was assessed by asking, "What is your ethnicity?" with two options: "Not Hispanic or Latino" and "Hispanic or Latino." Responses to the race and ethnicity questions were used to recode participants into five racial/ethnic identity categories used for analysis: Black/African American, Asian American and Pacific Islander (AAPI), Latinx/Hispanic, Multiracial/Other, and White.

### 2.3.2. Psychological distress

Given that, among adolescents, formal psychological help-seeking and patterns of psychological distress were significantly impacted by the COVID-19 pandemic (Chavira, Ponting, & Ramos, 2022), we assess and covary COVID-19 related distress. Psychological distress was assessed using an adapted version of the Impacts of the COVID-19 Outbreak on You scale from the Environmental Influences on Child Health Outcomes (ECHO) COVID-19 Questionnaire (Knapp et al., 2023), to describe degree of individual distress experienced by each participant within this unique societal context. Participants responded to items about their thoughts and feelings over the past six months on a five-point Likert-type scale from 1 = "Never" to 5 = "Very Often." The adapted version included six items assessing general psychological distress and

nine items assessing participants' thoughts and feelings regarding the COVID-19 pandemic, for example: "Since becoming aware of the COVID-19 (Coronavirus) outbreak, how often have you...been upset when you see something that reminds you of COVID-19?" Items were rated on a five-point Likert-type scale from 1 "Never" to 5 "Very Often" and averaged ( $\alpha = 0.87$ ).

### 2.3.3. Treatment stigma

**Personal Treatment Stigma.** Personal treatment stigma was assessed using the 10-item Self-Stigma of Seeking Help (SSOSH) scale (Vogel, Wade, & Haake, 2006), adapted for a 6th grade reading level. Participants responded to items inquiring about how they would feel about seeking mental health support (e.g., "I would feel like I wasn't good enough if I went to a therapist for help with my mental health (my feelings, mood, or behavior).") on a five-point Likert-type scale from 1 = "Strongly disagree" to 5 = "Strongly agree." Items were averaged to calculate the total score ( $\alpha = 0.80$ ).

**Caregiver and Peer Treatment Stigma.** Perceived mental health treatment stigma held by caregivers and peers was assessed using the five-item Perceptions of Stigmatization by Others for Seeking Help (PROSH) scale (Vogel, Wade, & Aschman, 2009), adapted for a 6th grade reading level. The language of the prompt was adapted to ask specifically about "parents/caregivers" or "peers (friends, classmates, other people you know your own age)" (see Supplement for complete, adapted scales administered). Participants responded to the scale regarding how they thought their parents/caregivers and their peers would respond if they wanted to pursue mental health services. They rated items (e.g., "Think of you in a less positive way.") on a five-point Likert-type scale from 1 = "Not at all" to 5 = "Extremely." Items were averaged to calculate the total score ( $\alpha = 0.87$  for parent stigma and 0.89 for peer stigma).

### 2.3.4. Formal psychological help-seeking

Participants' help-seeking behavior was assessed using the Actual Help Seeking Questionnaire (AHSQ; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Participants were asked: "Which of the following people have you talked with about your mental or emotional health (for example, your feelings, mood, or behavior) in the past year?" Participants indicated all sources of psychological support using checkboxes. A binary (yes/no) variable was generated to indicate whether participants had sought formal psychological support if they endorsed seeking support from the following options: school counselor, mental health professional outside of school, pediatrician, emergency room, inpatient or residential services, and substance use detox or rehab center.

### 2.3.5. Data quality questions

**Attention checks.** Two attention check questions were included: "Please choose [specific answer] for this question. This is just to see if you are paying attention". In this study, records were excluded if the student failed both attention checks.

**Completion checks.** Records were flagged based on degree of completion of non-branched questions (i.e., asked of the entire sample). Records were excluded if less than 60% of non-branched questions were complete.

## 2.4. Missing data

Among variables-of-interest, some systematic missingness occurred: 2 participants did not respond to the caregiver stigma scale only, 6 participants did not respond to the caregiver stigma scale or the peer stigma scale, and 14 participants did not respond to the personal stigma scale, peer stigma scale, and caregiver stigma scale. Participants who did not respond to stigma scales did not systematically differ on gender identity or racial identity, but they reported lower formal mental-health treatment seeking than participants without missing stigma data ( $t = 23.64, p < 0.001$ ), suggesting estimates in these models may be overall

underestimates of the degree to which participants are disconnected from formal mental health support.

Regarding the formal mental health support-seeking variable, 718 participants had missing data, but that missingness was not systematically associated with other model variables, including gender, race, or stigma variables. Overall, missingness appeared to reflect participant fatigue or survey time, with variables later in the survey demonstrating systematically more missingness (the formal mental health support seeking variable was administered at the end of the survey).

## 2.5. Analytic plan

Descriptive statistics, demographic characteristic analyses, and hypothesis-driven analyses were conducted in MPLUS (Muthén & Muthén, 2011). To investigate associations between mental health treatment stigma and gender and racial identity (Hypothesis 1), a series of analysis of variance (ANOVA) were run. Chi-square tests and logistic regressions were conducted to investigate associations between demographic variables (gender, racial and ethnic identities) and formal psychological help-seeking, with post-hoc analyses using adjusted *p*-value cutoffs for multiple comparisons. Post hoc Tukey's tests of comparisons were run in all cases where omnibus tests identified significant differences.

A structural equation model was built to test mediation from perceived treatment stigma through personal treatment stigma to formal psychological help-seeking (Hypothesis 2). The final mediation model included direct paths from personal treatment stigma, caregiver treatment stigma, and peer treatment stigma to formal psychological help-seeking, with mediated paths from perceived caregiver and peer treatment stigma through personal treatment stigma to formal psychological help-seeking, covarying race (entered as a categorical variable, with White as the referent), gender (entered as a categorical variable, with cis male as the referent), and psychological distress (entered as a continuous variable). Missing data was managed using weighted least squares mean and variance adjusted estimation (WLSMV). This was the chosen estimator given that it is robust to non-normality when doing complex modeling, which is necessary given the use of categorical outcomes and clustered data.

Beta coefficients for direct effects were interpreted based on Acock (2014):  $\beta < 0.2$  is small,  $0.2 \leq \beta < 0.5$  is medium, and  $\beta \geq 0.5$  is large. Because there is no consensus of effect size indicators for mediation in complex models (Preacher & Kelley, 2011; Wen & Fan, 2015; Wen, Fan, Ye, & Chen, 2016), effect sizes for mediation are not reported.

## 3. Results

Mean opt-out rates across schools were low ( $M = 1.0\%$ ,  $SD = 0.7\%$ ), and survey capture was high, with 75.5% ( $SD = 11.8\%$ ) of students enrolled in the six included schools participating. The final analytic sample included 3,248 students in 6–12th grade. Participants were majority cisgender female (51.2%) and non-Hispanic White (63.7%). See Table 1 for a more detailed description of the sample.

### 3.1. Descriptive statistics

Variable means, standard deviations, and correlations are presented for all analyzed variables in Table 2.

### 3.2. Primary results

**Hypothesis 1.** (Formal psychological help-seeking, personal mental health treatment stigma, and perceived peer and caregiver mental health treatment stigma will vary by youth race and gender.) **Formal psychological help-seeking.** Approximately one-third of the overall sample (32.5%;  $N = 1056$  adolescents) endorsed seeking psychological help from formal

**Table 1**

Sample demographic characteristics and formal psychological help sources ( $N = 3248$ ).

| Characteristic                                     | N    | %     |
|----------------------------------------------------|------|-------|
| <b>Grade</b>                                       |      |       |
| 6th                                                | 498  | 14.3% |
| 7th                                                | 566  | 16.2% |
| 8th                                                | 555  | 15.9% |
| 9th                                                | 500  | 14.3% |
| 10th                                               | 501  | 14.3% |
| 11th                                               | 448  | 12.3% |
| 12th                                               | 424  | 12.1% |
| (Missing data)                                     | 0    | 0.0%  |
| <b>Gender</b>                                      |      |       |
| Cisgender female                                   | 1664 | 51.2% |
| Cisgender male                                     | 1506 | 46.4% |
| Transgender and gender expansive (TGE)             | 62   | 1.9%  |
| Transgender male                                   | 5    | 0.2%  |
| Transgender female                                 | 10   | 0.3%  |
| Nonbinary                                          | 47   | 1.4%  |
| (Missing data)                                     | 16   | 0.5%  |
| <b>Race and Ethnicity</b>                          |      |       |
| Asian American/Pacific Islander (AAPI)             | 595  | 18.3% |
| Asian/Asian American                               | 592  | 18.2% |
| Hawaiian/Pacific Islander                          | 3    | 0.1%  |
| Black/African American (Non-Hispanic/Latinx)       | 126  | 3.9%  |
| Latinx/Hispanic                                    | 152  | 4.7%  |
| White (Non-Hispanic/Latinx)                        | 2069 | 63.7% |
| Multiracial/Other                                  | 290  | 8.9%  |
| Afro-Latinx                                        | 16   | 0.5%  |
| Indigenous/Native American                         | 34   | 1.1%  |
| Multiracial                                        | 177  | 5.5%  |
| West Asian/North African                           | 14   | 0.4%  |
| Other                                              | 49   | 1.5%  |
| (Missing data)                                     | 16   | 0.5%  |
| <b>Source of Formal Psychological Support</b>      |      |       |
| School counselor                                   | 549  | 16.9% |
| Mental health professional outside of school       | 491  | 15.1% |
| Pediatrician                                       | 538  | 16.6% |
| Emergency room, inpatient, or residential services | 54   | 1.7%  |
| Substance use detox or rehab center                | 8    | 0.2%  |

Note: Participants could select multiple sources of formal psychological support and % in these rows reflect the % of the overall sample that endorsed each option.

sources over the past year. In line with Hypothesis 1, differences in rates of formal psychological help-seeking were identified for both adolescents' racial identities and adolescents' gender identities (see Table 3).

White youth (36.4%) reported the highest levels of formal psychological help-seeking, when compared to students of all other racial and ethnic backgrounds ( $27.3\%$ ;  $\chi^2(1, N = 3,183) = 27.51, p < 0.001$ ). This difference was primarily driven by the difference between formal help-seeking reported by White youth ( $36.4\%$ ;  $\chi^2 = 27.46, p < 0.001$ ) and Asian American/Pacific Islander youth ( $21.9\%$ ;  $\chi^2 = 40.70, p < 0.001$ ). There were also significant differences in formal help-seeking by gender ( $\chi^2(2, N = 3,183) = 73.85, p < 0.001$ ). Youth identifying as transgender, nonbinary, and gender expansive reported higher levels of formal psychological help-seeking ( $48.3\%$ ;  $\chi^2 = 6.35, p = 0.012$ ) than both cisgender male and cisgender female youth. Cisgender female youth ( $39.4\%$ ;  $\chi^2 = 60.37, p < 0.001$ ) were more likely to report formal psychological support than cisgender male youth ( $25.6\%$ ;  $\chi^2 = 71.74, p < 0.001$ ).

**Personal Treatment Stigma.** Youth holding minoritized racial identities reported higher levels of personal treatment stigma ( $M = 2.54, SE = 0.61$ ) than White youth ( $M = 2.45, SE = 0.63, F(1, 3116) = 14.19, p < 0.001$ ). When examining differences among specific racial and ethnic identities ( $F(1, 3113) = 4.02, p = 0.003$ ), post hoc Tukey tests showed that differences between minoritized and White youth were driven by Asian American/Pacific Islander youth reporting significantly higher levels of personal treatment stigma ( $M = 2.56, SE = 0.62, p = 0.002$ ). There were also significant differences in personal treatment stigma by

**Table 2**Descriptive statistics and intercorrelations ( $N = 3248$ ).

| Variable                                       | M (SD)         | 1       | 2       | 3       | 4       | 5       | 6       | 7        |
|------------------------------------------------|----------------|---------|---------|---------|---------|---------|---------|----------|
| 1. Psychological Distress                      | 1.9<br>(0.65)  | --      | 0.28*** | 0.35*** | 0.33*** | 0.36*** | 0.01    | -0.04    |
| 2. Formal Help-Seeking (0=No, 1 = Yes)         | 0.17<br>(0.37) | 0.28*** | --      | 0.11*** | 0.08*** | 0.05    | 0.04    | -0.13*** |
| 3. Personal Mental Health Treatment Stigma     | 2.70<br>(0.52) | 0.35*** | 0.11*** | --      | 0.29*** | 0.28*** | -0.01   | 0.03     |
| 4. Peer Mental Health Treatment Stigma         | 1.60<br>(0.74) | 0.33*** | 0.08*** | 0.29*** | --      | 0.56*** | 0.02    | 0.04     |
| 5. Caregiver Mental Health Treatment Stigma    | 1.48<br>(0.70) | 0.36*** | 0.05*** | 0.28*** | 0.56*** | --      | 0.07*** | 0.13***  |
| 6. Minoritized Gender Identity (0=No, 1 = Yes) | —              | 0.01    | 0.04    | -0.01   | 0.02    | 0.07*** | --      | 0.01     |
| 7. Minoritized Racial Identity (0=No, 1 = Yes) | —              | -0.04*  | -0.13   | 0.03    | 0.04*   | 0.13*** | 0.01    | —        |

Note: \*\*\* $p < 0.001$ , \* $p < 0.05$ ; entries above the diagonal are adjusted for multiple comparisons.

Minoritized racial identity categorized as 0 = White, 1 = all other racial identities.

Minoritized gender identity categorized as 0 = Boy/man/male or Girl/woman female, 1 = all other gender identities.

**Table 3**

Personal treatment stigma, perceptions of caregiver and peer treatment stigma, and formal psychological help-seeking across identity groups.

|                                   | M (SD)                           |                         |                  |                             |                  |                    |
|-----------------------------------|----------------------------------|-------------------------|------------------|-----------------------------|------------------|--------------------|
|                                   | Asian American, Pacific Islander | Black, African American | Latin(x)         | Multiracial, Other Identity | White            | Omnibus Comparison |
| Personal Treatment Stigma         | 2.56 (0.62)*                     | 2.49 (0.62)             | 2.55 (0.56)      | 2.52 (0.61)                 | 2.45 (0.63)<br>* | 4.02**             |
| Caregiver Treatment Stigma        | 1.64 (0.79)*                     | 1.53 (0.75)             | 1.67 (0.78)<br>† | 1.54 (0.78)                 | 1.42 (0.65)*†    | 14.09***           |
| Peer Treatment Stigma             | 1.63 (0.72)                      | 1.55 (0.71)             | 1.68 (0.75)      | 1.72 (0.80)                 | 1.59 (0.74)      | 2.40*              |
| Formal Psychological Help-Seeking | 21.9%*                           | 31.2%                   | 34.9%            | 32.6%                       | 36.4%*           | 27.51***           |

|                                       | M(SD)          |                  |                                    | Omnibus Comparison |
|---------------------------------------|----------------|------------------|------------------------------------|--------------------|
|                                       | Cisgender Male | Cisgender Female | Trans, Nonbinary, Gender Expansive |                    |
| Personal Treatment Stigma             | 2.51 (0.61)    | 2.46 (0.63)*     | 2.66 (0.72)*                       | 4.95**             |
| Caregiver Treatment Stigma            | 1.40 (0.60)*†  | 1.53 (0.73)*†    | 2.42 (1.20)*†                      | 70.56***           |
| Peer Treatment Stigma                 | 1.58 (0.70)*   | 1.61 (0.74)†     | 2.31 (1.13)*†                      | 28.71***           |
| Formal Psychological Help-Seeking (%) | 25.6%*         | 39.4%*           | 48.3%*                             | 89.11***           |

Note: Omnibus comparisons for personal, caregiver, and peer treatment stigma are represented by F values; omnibus comparisons for formal psychological help-seeking are represented by  $\chi^2$  values.Statistically significant differences between groups ( $p < 0.05$ ) in post hoc Tukey tests of comparisons are denoted by matching symbols within row. In the case where all groups are significantly different from one another (Formal Psychological Help-Seeking by Gender Identity), all columns have matching symbols.

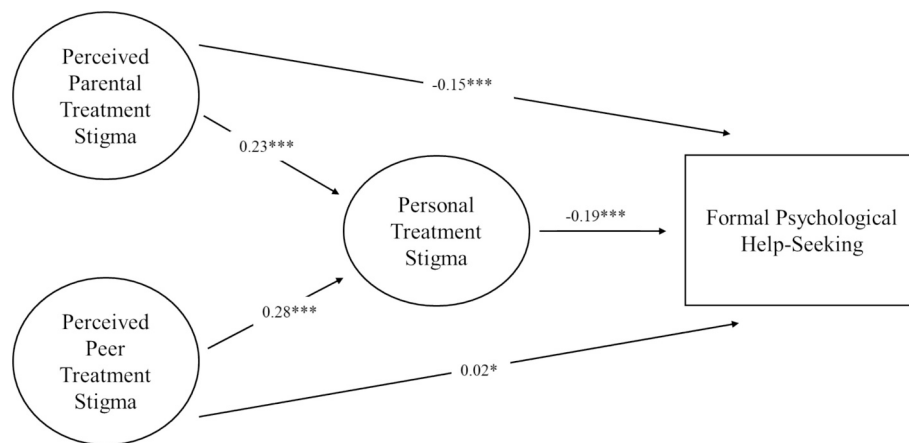
gender ( $F(2, 3115) = 4.95, p = 0.007$ ). Transgender, nonbinary, and gender expansive youth reported the highest levels of personal treatment stigma ( $M = 2.66, SE = 0.72$ ), which were significantly higher than the personal treatment stigma reported by cisgender female youth ( $M = 2.46, SE = 0.63, p = 0.007$ ). Cisgender male youth reported marginally higher levels of personal treatment stigma ( $M = 2.51, SD = 0.61$ ) than cisgender female youth ( $p = 0.057$ ).

**Caregiver and Peer Treatment Stigma.** Caregiver treatment stigma varied by race ( $F(4, 3129) = 14.09, p < 0.001$ ). Asian American/Pacific Islander youth ( $M = 1.64, SE = 0.79, p < 0.001$ ) and Latinx/Hispanic youth ( $M = 1.67, SE = 0.78, p < 0.001$ ) reported significantly higher levels of perceived caregiver treatment stigma than White youth ( $M = 1.42, SE = 0.65, p < 0.001$ ).

Caregiver treatment stigma also varied significantly by gender ( $F(2, 3132) = 70.56, p < 0.001$ ). Cisgender male youth reported the lowest levels of caregiver treatment stigma ( $M = 1.40, SD = 0.60$ ) and transgender and nonbinary youth reported the highest ( $M = 2.42, SD = 1.20$ ). Peer treatment stigma varied significantly by gender ( $F(2, 3130) = 28.71, p < 0.001$ ). Transgender, nonbinary, and gender expansive youth reported significantly higher levels of peer treatment stigma ( $M = 2.31, SD = 1.13$ ) than cisgender male ( $M = 1.58, SD = 0.70$ ) and cisgender female youth ( $M = 1.61, SD = 0.74$ ).

**Hypothesis 2.** (In a mediation model, after controlling for youth racial identity, gender identity, and psychological distress, greater peer and caregiver treatment stigma will be associated with higher levels of personal treatment stigma, which in turn will predict lower likelihood of formal psychological help-seeking.) The final mediation model demonstrated adequate fit to the data (RMSEA = 0.026 [95%CI = 0.025,.027]; CFI = 0.89, TLI = 0.87, SRMR = 0.07) and partially supported [Hypothesis 2](#). Significant direct and indirect associations from caregiver and peer treatment stigma to formal psychological help seeking were identified, with partial mediation through personal treatment stigma (see [Fig. 1](#); [Table 4](#); covariate paths in [Supplemental Table 1](#)).

Personal treatment stigma was identified as a partial mediator of the associations between caregiver and peer treatment stigma on formal psychological help-seeking. Both caregiver treatment stigma ( $b = 0.23, SE = 0.03; 95\% CI [0.17, 0.29], p < 0.001$ ) and peer treatment stigma ( $b = 0.28, SE = 0.04, 95\% CI [0.20, 0.36], p < 0.001$ ) were associated with higher personal treatment stigma. Personal treatment stigma was negatively associated with formal help-seeking ( $b = -0.19, SE = 0.04, OR = 0.83, 95\% CI [0.76, 0.90], p < 0.001$ ), such that for every one unit increase in personal treatment stigma, participants were 17% less likely to report seeking formal psychological support.



**Fig. 1.** Mediation of perceived caregiver and peer treatment stigma via personal treatment stigma on adolescent formal psychological help-seeking ( $N = 3248$ ) Model covaried participant gender identity, racial/ethnic identity, and psychological distress.

**Table 4**

Effect estimates: mediation model examining peer and caregiver treatment stigma, personal treatment stigma, and formal psychological help-seeking.

| Path                                                                                   | <i>b</i> | SE      | 95% CI          |
|----------------------------------------------------------------------------------------|----------|---------|-----------------|
| Caregiver treatment stigma → Personal treatment stigma                                 | 0.23***  | 0.03*** | 0.17, 0.29***   |
| Peer treatment stigma → Personal treatment stigma                                      | 0.28***  | 0.04*** | 0.20, 0.36***   |
| Personal treatment stigma → Formal help-seeking                                        | -0.19*** | 0.04*** | -0.27, -0.11*** |
| Direct: Caregiver treatment stigma → Formal help-seeking                               | -0.15*** | 0.02*** | -0.19, -0.11*** |
| Direct: Peer treatment stigma → Formal help-seeking                                    | 0.02*    | 0.01*   | 0.00, 0.04*     |
| Indirect: Caregiver treatment stigma → Personal treatment stigma → Formal help-seeking | -0.04**  | 0.01**  | -0.07, -0.02**  |
| Indirect: Peer treatment stigma → Personal treatment stigma → Formal help-seeking      | -0.05**  | 0.02**  | -0.08, -0.03**  |

Note: \* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$ .

The indirect (mediated) effects of caregiver mental health treatment stigma and peer mental health treatment stigma on formal help-seeking through personal mental health treatment stigma were statistically significant. In both cases, small but significant effects were observed such that higher caregiver or peer stigma was associated with indirect reductions in adolescents' likelihood of seeking formal psychological support through increases in personal treatment stigma. The path from caregiver treatment stigma to formal psychological help-seeking through personal treatment stigma was significant at  $b = -0.044$  ( $SE = 0.012$ , 95% CI  $[-0.07, -0.02]$ ,  $p < 0.001$ ). The path from peer treatment stigma to formal psychological help-seeking through personal treatment stigma was significant at  $b = -0.05$  ( $SE = 0.02$ , 95% CI  $[-0.02, -0.03]$ ,  $p < 0.001$ ).

In addition to indirect effects, caregiver stigma also exerted a significant direct effect on help-seeking. Higher levels of caregiver treatment stigma were directly associated with lower levels of formal help-seeking ( $b = -0.15$ ,  $SE = 0.02$ ,  $OR = 0.86$ , 95% CI  $[0.82, 0.91]$ ,  $p < 0.001$ ), such that for every one unit increase in caregiver treatment stigma, participants were 14% less likely to report seeking formal psychological support. However, contrary to hypotheses, peer treatment stigma was *positively* associated with formal help-seeking, such that higher levels of peer treatment stigma were associated with slightly higher levels of formal help-seeking ( $b = 0.02$ ,  $SE = 0.01$ ,  $OR = 1.03$ , 95% CI  $[1.00, 1.06]$ ,  $p = 0.018$ ), such that for every one unit increase in peer treatment stigma, participants were 3% more likely to report seeking formal psychological support.

#### 4. Discussion

The current study identified differences in perceptions of mental health treatment stigma and behavioral psychological help-seeking among adolescents holding diverse racial and gender identities, and identified pathways from treatment stigma to reductions in seeking formal psychological support. Treatment stigma often reflects historic mistreatment by mental health providers and it is critical to understand and address the downstream implications of such stigma among adolescents and their community members. Consistent with prior studies (e.g., Jon-Ubabuco & Dimmitt Champion, 2019; Wong et al., 2020), experiences of treatment stigma and tendency to seek formal support were each associated with aspects of racial, ethnic, and gender identities. Moreover, after accounting for gender, race, and degree of psychological distress, adolescents' own stigma and their perceptions of close others' stigma was linked to whether they seek formal psychological support. In this sample, caregiver and peer treatment stigma were associated with higher personal treatment stigma, which was in turn associated with reduced likelihood of seeking formal psychological support. Additionally, for every one unit increase in caregiver treatment stigma, participants were 14% less likely to report seeking formal psychological support. However, for every one unit increase in peer treatment stigma, participants were 3% more likely to report seeking formal psychological support. Findings are discussed using developmental and socio-contextual lenses, below.

Youths' personal treatment stigma was associated with treatment stigma held by their peers and their caregivers. Peer beliefs, in general, are associated with personal beliefs (Scheffer, Borsboom, Nieuwenhuis, & Westley, 2022) and caregiver attitudes are associated with youth attitudes (Paula et al., 2022). When incorporating both caregiver and peer influences in the same model, we see that *both* maintain significant contributions to an adolescent's personal beliefs about formal psychological treatment. This finding is a key developmental consideration, given that much of the adolescent literature focuses on the normative shift in social focus from caregiver to peer relationships and has only recently begun grappling with the unique and overlapping contributions of caregiver and peer influence (e.g., Allen et al., 2022).

Examining the interrelations among caregiver and peer stigma is critical to understanding adolescent treatment stigma, psychological help-seeking behaviors, and broader patterns in adolescent mental health. The direct, negative association between personal treatment stigma and help-seeking has already been well-documented in the literature (Clement et al., 2015; Mojtabai, Evans-Lacko, Schomerus, & Thornicroft, 2016). Building on this literature, the current study further clarifies the role of external sources of stigma, both in shaping personal stigma and in directly predicting psychological help-seeking among

adolescents. In this sample, after accounting for the association among personal and caregiver stigma, perceived caregiver stigma was *also* negatively associated with formal help-seeking. Adolescents' perceptions of their caregivers' stigma exerted far more influence on their psychological help-seeking behaviors than attitudes. This may be related to the significant instrumental role that caregivers play in adolescents' mental health treatment, given that such treatment requires caregiver resources and/or consent prior to initiation (Dempster, Wildman, & Keating, 2013). The intergenerational transmission of oppressive and traumatic experiences is a potent factor for families from minoritized racial identities (Heberle, Obus, & Gray, 2020) and may also facilitate transmission of mental health treatment stigma within these families. Caregivers who hold mental health treatment stigma, particularly caregivers from African American, Latin American, Indigenous American, and other minoritized racial backgrounds have likely experienced both direct and indirect mistreatment from the mental health and associated healthcare and education systems (Suite, La Bril, Primm, & Harrison-Ross, 2007). To address understandable mistrust, it is key that the mental health field scaffold cultural humility in its providers (Orlowski, Moeyaert, Monley, & Redden, 2025) and continue to support training diverse clinicians (Moore, Coates, & Watson, 2023; Ramos, Brookman-Frazee, Kodish, Rodriguez, & Lau, 2021) for minoritized patients to receive restorative care and develop trust in the system.

In contrast to the impact of caregiver stigma, adolescents' perceptions of their peers' treatment stigma were associated with a greater likelihood of seeking formal psychological help themselves, contrary to prior literature showing that higher levels of perceived public stigma predict lower help-seeking intentions (Calear, Batterham, Torok, & McCallum, 2021; Nearchou et al., 2018). Notably, most prior literature focused on help-seeking *intentions* rather than actual help-seeking behavior and has examined broader perceptions of stigma (e.g., school stigma, public stigma), rather than stigma from peers, specifically. Given adolescents' sensitivity to the social costs of their own actions (Van Hoorn, McCormick, & Telzer, 2018), some adolescents may expect that their peers would disapprove of their connection to formal psychological supports, which could shape adolescents' help-seeking tendencies. Additional research is needed to truly identify whether—and, if so, how—this small effect is meaningful, and for which adolescents.

In addition to the role of stigma, this study also identified disparity in formal psychological help-seeking by racial/ethnic and gender identities. In general, this sample endorsed relatively high rates of formal help-seeking over the past year (32.5%), compared to previous national studies of youth aged 12 to 17 during that same year (16.8%; Zablotsky & Terlizzi, 2020). That said, White youth reported a higher rate of formal psychological help-seeking than minoritized youth. It is crucial to contextualize this finding in the ongoing systemic racism and structural barriers that prevent minoritized youth from accessing formal supports. Many factors—including prior experiences of and/or anticipatory fear of clinician bias, underrepresentation of clinicians holding diverse racial, ethnic, and gender identities, and the lack of culturally responsive clinicians—are significant deterrents to formal psychological help-seeking among minoritized youth (Metzger et al., 2023). In the short term, amidst ongoing systemic barriers to equitable access, schools may serve as an access point through the establishment of school-based clinics, hiring a diverse workforce, and cultivating cultural responsiveness. Longer-term, societal shifts are needed to address the many barriers that have rendered formal psychological supports a resource that is most often accessed by wealthy, White individuals (West, Conn, Lindquist, & Dews, 2023). Clinician training should include cultural assessments that ask patients directly about their perceptions of help-seeking, past experiences with psychological support, and cultural stigma, such as the Cultural Formulation Interview (CFI; Jarvis, Kirmayer, Gómez-Carrillo, Aggarwal, & Lewis-Fernández, 2020). Discussions of stigma that are patient-driven may promote adolescents' treatment engagement, increase care supportiveness, and bolster future mental health care use (Sanchez, 2019).

Psychological help-seeking also varied by gender, with cisgender male youth reporting significantly lower rates of formal help-seeking than cisgender female youth. These gender differences mirror extensive literature on gender differences in help-seeking (Haavik, Joa, Hatloy, Stain, & Langeveld, 2019; Rickwood et al., 2005), which is conceptualized as being motivated by higher rates of personal stigma associated with stereotypically masculine gender norms (Wahto & Swift, 2016). This is especially relevant given documented links between conformity to masculine gender norms (e.g., power over women, self-reliance, and heightened sexuality), reduced psychological help-seeking, and increased risk for adverse mental health outcomes, including increases in depressive symptoms, stress, loneliness, and substance use, and decreases in self-esteem, life satisfaction, and psychological well-being (Wong et al., 2017). Regarding perceived stigma, cisgender female youth reported higher levels of perceived parental treatment stigma than cisgender male youth. Some prior literature suggests that cisgender female youth may be more attuned to the attitudes of others and therefore notice and report more stigma (Flannery & Smith, 2017). Considering established differences in caregiving dynamics for boys and girls in adolescence (for instance, caregivers of girls reinforcing treatment-seeking or expression of emotion more than caregivers of boys; Triemstra, Niec, Peer, & Christian-Brandt, 2017), this phenomenon may be particularly salient for girls perceiving that their parents hold treatment stigma. There were no gender-based differences in perceptions of peer treatment stigma in this sample.

Transgender, nonbinary, and gender expansive (TGE) youth reported the highest levels of formal psychological help-seeking, with nearly half of TGE youth in the sample reporting formal psychological supports. This is unexpected, given previous work highlighting that gender minoritized youth are also much more likely to report unmet mental health needs, and were particularly vulnerable in the time immediately after the onset of the COVID-19 pandemic (Hawke, Hayes, Darnay, & Henderson, 2021). Youth in this sample reside in [STATE], where protective laws and access to mental health care may have combatted some of this care gap. At the same time, TGE youth in this sample endorsed significantly higher rates of personal, perceived peer, and perceived caregiver treatment stigma. Several explanations may account for this finding. For example, it is possible that these youth feel strong cognitive dissonance about seeking treatment or have had negative treatment experiences yet continue to receive services to access gender-affirming care. It is critical to contextualize these results, both in terms of the policy landscape when data were collected and at the time of this write-up. Data were collected in 2020, and since then, policy changes have made it increasingly challenging for youth to seek gender affirming care. Currently, 40% of all youth live in a state banning gender affirming care, and in some states, providers face professional discipline if they offer gender affirming care to youth (Dawson & Kates, 2025). For youth holding minoritized identities, the combination of identity stress, internalized treatment stigma, ongoing marginalization, and sociocultural stigmatization of their identity and their care can amplify existing psychological risk, as well as risk to physical safety (Sapiro & Ward, 2020).

Importantly, each adolescent does not hold their gender, racial, and other identities as separate factors that shape their experience. Rather, the intersection of racial and gender identities generates a unique relationship to mental health care for each adolescent (Fox, Choukas-Bradley, Salk, Marshal, & Thoma, 2020). This intersectionality may compound the experience of stigma and barriers to help-seeking, if they hold multiple marginalized identities. For example, if youth hold minoritized racial identities and gender identities, they may struggle to identify providers that are affirming of all aspects of their identity and must prioritize treatment of some symptoms while leaving other aspects of their identity unaddressed (Vance et al., 2024). These sorts of compromises, while demonstrating flexibility on the part of the adolescent in the short-term, represent a significant failure of the mental health system, in the long-term. The chronic stress of managing multiple

marginalized identities when navigating the mental health care system imposes additional inequities for these populations, which need additional attention in future work.

## 5. Limitations and future directions

Study limitations must be considered. We acknowledge that the study relies on a single-reporter, and future work would do well to integrate assessments of caregivers' and peers' *self-reported* treatment stigma to investigate how well these may or may not relate to adolescents' *perceptions* of these close others' stigma. This means that unmeasured processes within adolescents, such as culturally-driven stigma within the community, may be shaping perceptions of self-, peer-, and caregiver-held stigma. Additionally, the cross-sectional design allowed for only a singular snapshot of these associations. The larger survey from which these questions are drawn focuses on substance use and mental health, and it is possible that this context shaped students' responses. For instance, students from minoritized and criminalized social groups may disclose less, with fears of disciplinary action. Given this context, we propose that these findings put forth a foundation for focused longitudinal work that should be undertaken to understand temporal associations among other-stigma, self-stigma, and formal psychological help-seeking, with close attention to adolescent identity and cultural factors.

Furthermore, although the study made efforts to disentangle the role of identity in associations among stigma and psychological help-seeking, it is important to note that this sample consists of mostly non-Hispanic, White, cisgender adolescents. As a result, these findings may not generalize to young people whose identity backgrounds are under-represented—and therefore underpowered—in this study. It is also possible that minoritized youth, who experience more stigma in this sample, may be systematically more likely to have missing data. Future work would be strengthened by incorporating a measure of school and community representation into analyses about formal psychological help-seeking, and by exploring such constructs in samples of predominantly minoritized students. Additionally, this study did not disentangle differences in the associations of stigma and help-seeking based on the intersectional identities represented in this sample and may not generalize to all adolescents. Qualitative data is important to capture adolescents' own words in describing their experiences with the mental health care system, and to deepen our understanding of their stigma perceptions and treatment experiences.

Finally, the current study is limited by its highly unique context of collecting data roughly six months into the global COVID-19 pandemic. While we made efforts to statistically account for the effects of COVID-19 in shaping adolescent behaviors and interpret our findings considering that context, replication of these results will be important. It is also possible that changes in the environment surrounding youth and their relationship to mental health care have changed significantly in the past five years. Although youth-to-youth messaging about mental health stigma may have trended toward more positive messaging around seeking mental health support, adolescents are also taking in competing, negative messaging on the part of larger governmental systems in the United States. More socioecological work is needed to understand individual adolescents' relationships to the multiply layered systems that shape their personally held beliefs and behaviors with regard to mental health care.

## 6. Implications for policy and practice

Combatting stigma is essential to ensuring that adolescents receive timely and equitable mental health care. The current findings highlight the need for stigma reduction strategies that target not only adolescents, but also the caregivers and peers whose beliefs shape youth attitudes toward help-seeking. Initiatives in schools, communities, and other youth-serving organizations should incorporate psychoeducation and

open dialogue about mental health treatment to normalize help-seeking and reduce misperceptions about mental health care's utility and rate of use (McPhail, Thornicroft, & Gronholm, 2024). Given that caregiver stigma showed a particularly strong association with adolescents' personal stigma and help-seeking behaviors, family-focused interventions may also prove especially effective. Incorporating discussions of mental health into physicians' appointments, incorporating caregivers into school mental health programs, or family workshops are some examples of the range of ways in which caregivers may be encouraged to consider mental health care as a standard component of youths' upbringing. Each of these and other interventions could be supported by policies that promote mental health literacy among adults, in general, to encourage cultural shifts in caregivers' relationships to mental health treatment in the US. Critically, it is not simply the job of caregivers to improve their relationship to the mental health system: the mental health system has chronically failed to support diverse patients, which has ultimately reinforced stigma for many people across the globe (Vinson et al., 2020). Mental health systems must increase cultural sensitivity and responsiveness through expanding the diversity of the behavioral health workforce, removing barriers to care, increasing providers' cultural responsiveness, and acknowledging the sociohistorical roots of mental health treatment stigma. As noted above, practitioners should receive training in cultural influences on stigma and help-seeking, and take an active role in providing patients with the opportunity to discuss stigma and relationships to mental health treatment.

## 7. Conclusion

By integrating caregiver, peer, and personal stigma within a single model, this study highlights potential social mechanisms through which stigma may perpetuate mental health disparities. These results suggest that adolescents' perceptions of treatment stigma, especially stigma held by their caregivers, may shape both personal treatment stigma and psychological help-seeking among adolescents. Personal treatment stigma partially mediated associations from caregiver and peer stigma to help-seeking, suggesting that adolescents' internally held stigma plays an important role in mental health decision-making. Additionally, differences in rates of stigma and psychological help-seeking emerged across sociodemographic groups: Asian American, Latinx, and gender expansive youth reported higher levels of personal and caregiver-held stigma, while White youth reported the highest rates of formal help-seeking. This integrated model not only highlights stigma's proximal mechanisms but reframes disparities as potentially socially transmitted, urging paradigm shifts from personal to relational interventions. Overall, findings should be interpreted in light of study limitations, including the cross-sectional design and reliance on self-report, and future work should employ longitudinal and multi-informant designs to clarify developmental pathways linking stigma and help-seeking. Despite these limitations, the identified associations underscore the imperative for longitudinal, timely, and equity-oriented research that informs policy. Prioritizing longitudinal, multi-informant designs to understand peer stigma's role in shaping adolescent help-seeking beliefs and behaviors may catalyze culturally responsive, stigma-reducing strategies that promote equitable access to mental health care for all youth.

## Declaration of competing interest

The authors have no conflicts of interest to declare that are relevant to the content of this article. This study was approved by the Massachusetts General Brigham IRB.

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## Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.chilcyouth.2026.108836>.

## Data availability

Data will be made available on request.

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